RULES
OF
THE TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-26
STANDARDS FOR HOME CARE ORGANIZATIONS PROVIDING HOME HEALTH SERVICES

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1200-8-26-.01 DEFINITIONS.

(1) Administrator. A person who:

(a) Is a licensed physician with at least one (1) year supervisory or administrative experience in home health care, hospice care or related health programs; or

(b) Is a registered nurse with at least one (1) year supervisory or administrative experience in home health care, hospice care or related health programs; or

(c) Has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care, hospice care or related health programs.

(2) Advance Directive. A written statement such as a living will, a durable power of attorney for health care or a do not resuscitate order relating to the provision of health care when the individual is incapacitated.

(3) Agency. A Home Care Organization providing home health services.

(4) Board. The Tennessee Board for Licensing Health Care Facilities.

(5) Branch Office. A location or site from which a home care organization provides home health services within a portion of the total geographic area served by the licensed organization. The branch office is part of the home care organization providing home health services and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the requirements for licensing as a home care organization providing home health services. At all times a branch office must operate solely under the name of the licensed organization.

(6) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to support cardiopulmonary functions in a patient, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilations or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a patient where cardiac or respiratory arrest has occurred or is believed to be imminent.

(Rule 1200-8-26-.01, continued)

(7) Certified Master Social Worker. A person currently certified as such by the Tennessee Board of Social Worker Certification and Licensure.

(8) Clinical Note. A written and dated notation containing a patient assessment, responses to medications, treatments, services, any changes in condition and signed by a health team member who made contact with the patient.

(9) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(10) Competent. A patient who has decision-making capability.

(11) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:

(a) the action(s) implemented to prevent the reoccurrence of the unusual event,

(b) the time frames for the action(s) to be implemented,

(c) the person(s) designated to implement and monitor the action(s), and

(d) the strategies for the measurements of effectiveness to be established.

(12) Decision-making capacity. Decision-making capacity is shown by the fact that the person is able to understand the proposed procedure, its risks and benefits, and the available alternative procedures.

(13) Department. The Tennessee Department of Health.

(14) Do Not Resuscitate (DNR) Order. An order entered by the patient's treating physician in the patient's medical record which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.

(15) Hazardous Waste. Materials whose handling, use, storage and disposal are governed by local, state or federal regulations.

(16) Health care decision. A decision made by an individual or the individual's health care decision-maker, regarding the individual's health care including but not limited to:

(a) the selection and discharge of health-care providers and institutions;

(b) approval or disapproval of diagnostic tests, surgical procedures, programs of administration of medication, and orders not to resuscitate;

(c) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care; and

(d) transfer to other health care facilities.

(17) Health Care Decision-maker. In the case of an incompetent patient, or a patient who lacks decision-making capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an advance directive, the patient's court-appointed legal guardian or

conservator with health care decision-making authority, or the patient's surrogate as determined pursuant to Rule 1200-8-26-.13 or T.C.A. §33-3-220.

(18) Home Care Organization. As defined by T.C.A. § 68-11-201, a "home care organization" provides home health services, home medical equipment services or hospice services to patients on an outpatient basis in either their regular or temporary place of residence.

(19) Home Health Aide. A person who has completed a total of seventy-five (75) hours of training which included sixteen (16) hours of clinical training prior to or during the first three (3) months of employment and who is qualified to provide basic services, including simple procedures as extension of therapy services, personal care regarding nutritional needs, ambulation and exercise, and household services essential to health care at home.

(20) Home Health Service. As defined by T.C.A. § 68-11-201, "home health service" means a service provided an outpatient by an appropriately licensed health care professional or an appropriately qualified staff member of a licensed home care organization in accordance with orders recorded by a physician, and which includes one (1) or more of the following:

(a) Skilled nursing care including part-time or intermittent supervision;

(b) Physical, occupational or speech therapy;

(c) Medical social services;

(d) Home health aide services;

(e) Medical supplies and medical appliances, other than drugs and pharmaceuticals, when provided or administered as part of or through the provision of, the services described in subparagraph (a) through (d) ; and

(f) Any of the foregoing items and services which are provided on an outpatient basis under arrangements made by the home care organization at a hospital, nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in the individual's home, or which are furnished at such facility while the individual is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(g) Home health service does not include services provided in the home by a sole practice therapist, when such services are within the scope of the therapist's license and incidental to services provided by the sole practice therapist in the office. A sole practice therapist means a therapist licensed under Title 63, Chapter 13 or 17, who is in sole practice and not in a business arrangement with any other therapist or other healthcare provider. Sole practice therapists are not excluded from the requirements of professional support services.

(21) Homemaker Service. A non-skilled service in the home to maintain independent living which does not require a physician's order. An agency does not have to be licensed as a home care organization to provide such services.

(22) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(23) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(24) Lacks Decision-Making Capacity. Lacks Decision-Making Capacity means the factual demonstration by the attending physician and the medical director, or the attending physician and another physician that an individual is unable to understand:

(a) A proposed health care procedure(s), treatment(s), intervention(s), or interaction(s);

(b) The risks and benefits of such procedure(s), treatment(s), intervention(s) or interaction(s); and

(c) The risks and benefits of any available alternative(s) to the proposed procedure(s), treatment(s), intervention(s) or interaction(s).

(25) Legal Guardian. Any person authorized to act for the resident pursuant to any provision of T.C.A. §§34-5-102(4) or 34-11-101, or any successor statute thereto.

(26) Licensed Clinical Social Worker. A person currently licensed as such by the Tennessee Board of Social Workers.

(27) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(28) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(29) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(30) Medical Record. Medical histories, records, reports, clinical notes, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries and other written electronic, or graphic data prepared, kept, made or maintained in an agency that pertains to confinement or services rendered to patients.

(31) Medical Social Services. When provided, shall be given by a certified master social worker, a licensed clinical social worker, or by a social worker or social work assistant employed by the home care organization and under the supervision of a certified master social worker or licensed clinical social worker, in accordance with the plan of care. The medical social services provider shall assist the physician and other team members in understanding the significant social and emotional factors related to the health problems, participate in the development of the plan of care, prepare clinical and progress notes, work with the family, utilize appropriate community resources, participate in discharge planning and in-service programs, and act as a consultant to other organized personnel.

(32) Medically Futile Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the informed patient. In the case of the incompetent patient, the surrogate expresses the goals of the patient.

(33) Occupational Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(34) Occupational Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(35) Patient. Includes but is not limited to any person who is suffering from an acute or chronic illness or injury or who is crippled, convalescent or infirm, or who is in need of obstetrical, surgical, medical, nursing or supervisory care.

(Rule 1200-8-26-.01, continued)

(36) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.

(37) Physical Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(38) Physical Therapy Assistant. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(39) Physician. A person currently licensed as such by the Tennessee Board of Medical Examinations or currently licensed by the Tennessee Board of Osteopathic Examination. For the purposes of defining "home health services" only, "physician" includes a podiatrist licensed under Title 63, Chapter 3, provided, that any home health service ordered is a follow-up to treatment provided to the patient by the podiatrist. A physician who is licensed to practice medicine, osteopathy or podiatry in a state contiguous to Tennessee may refer a patient residing in this state to a home care organization providing home health services duly licensed under this chapter; however, this shall not be construed as authorizing an unlicensed physician to practice medicine in violation of T.C.A. §§63-6-201, 63-9-104 or 63-3-204, and such a physician shall have previously provided treatment to that patient, and shall have had an ongoing physician-patient relationship with the person for whom the referral is to be made.

(40) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(41) Respiratory Technician. A person currently licensed as such by the Tennessee Board of Respiratory Care.

(42) Respiratory Therapist. A person currently licensed as such by the Tennessee Board of Respiratory Care.

(43) Shall or Must. Compliance is mandatory.

(44) Social Work Assistant. A person who has a baccalaureate degree in social work, psychology, sociology or other field related to social work, and has at least one (1) year of social work experience in a health care setting. Social work related fields include bachelor/masters degrees in psychology, sociology, human services (behavioral sciences, not human resources), masters degree in counseling fields (psychogicial guidance and guidance counseling) and degrees in gerontology.

(45) Speech Therapist. A person currently licensed as such by The Tennessee Board of Communication Disorders and Sciences.

(46) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board or equivalent body.

(47) Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity. Periodic supervision must be provided if the person is not a licensed or certified assistant, unless otherwise provided in accordance with these rules.

(Rule 1200-8-26-.01, continued)

(48) Surrogate. The resident's legal guardian, or if none, a competent adult most likely to know the wishes of the resident with respect to the possible withholding of resuscitative services or withdrawal of resuscitative services.

(49) Unusual Event. The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition.

(50) Unusual Event Report. A report form designated by the department to be used for reporting an unusual event.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed May 27, 2004; effective August 10, 2004.*

1200-8-26-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation or any state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate or maintain in the State of Tennessee any Home Care Organization providing Home Health Services without having a license. A license shall be issued to the person or persons named and for the premises listed in the application for licensure and for the geographic area specified by the certificate of need or at the time of the original licensing. The name of the agency shall not be changed without first notifying the Department in writing. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the agency.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the Department.

(b) Each applicant for a license shall pay an annual license fee of $800.00. The fee must be submitted with the application and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the Department. Patients shall not be admitted to the agency until a license has been issued. Applicants shall not hold themselves out to the public as being an agency until the license has been issued. A license shall not be issued until the agency is in substantial compliance with these rules, including submission of all information required by T.C.A. §68-11-206(1) or as later amended, and all information required by the Commissioner.

(d) The applicant must prove the ability to meet the financial needs of the agency.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the Department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the Department before the license may be issued.

(a) For the purposes of licensing, the licensee of an agency has the ultimate responsibility for the operation of the agency, including the final authority to make or control operational decisions

and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the agency's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the agency is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to the following:

1. Transfer of the agency's legal title;

2. Lease of the agency's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the agency;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the agency is owned by a limited partnership;

6. Merger of an agency owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate agency owner with one or more corporations; or

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the agency. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the agency's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the exact same legal form as the former owner.

(4) To be eligible for a license or renewal of a license, each agency shall be periodically inspected for compliance with these regulations. If deficiencies are identified, an acceptable plan of correction shall be established and submitted to the Department.

(Rule 1200-8-26-.02, continued)

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed November 19, 2003; effective February 2, 2004.*

1200-8-26-.03 DISCIPLINARY PROCEDURES.

(1) The Board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the agency or the patient's home;

(d) Conduct or practice found by the Board to be detrimental to the health, safety, or welfare of the patients of the agency; or

(e) Failure to renew the license.

(2) The Board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the patient of the agency;

(c) The conduct of the agency in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(d) Any prior violations by the agency of statutes, rules or orders of the Board.

(3) Inappropriate transfers are prohibited and violation of the transfer provisions shall be deemed sufficient grounds to suspend or revoke an agency's license.

(4) When an agency is found by the Department to have committed a violation of this chapter, the Department will issue to the agency a statement of deficiencies. Within ten (10) days of receipt of the statement of deficiencies the agency must return a plan of correction indicating the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(5) Either failure to submit a plan of correction in a timely manner or a finding by the Department that the plan of correction is unacceptable shall subject the agency's license to possible disciplinary action.

(6) Any licensee or applicant for a license, aggrieved by a decision or action of the Department or Board, pursuant to this chapter, may request a hearing before the Board. The proceedings and judicial review

(Rule 1200-8-26-.03, continued)

of the Board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000.*

1200-8-26-.04 ADMINISTRATION.

(1) The home health agency must organize, manage and administer its home health services to attain and maintain the highest practicable functional capacity for each patient regarding medical, nursing and rehabilitative needs as indicated by the plan of care.

(2) The home health agency shall ensure a framework for addressing issues related to care at the end of life.

(3) The home health agency shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(4) The agency develops and maintains administrative control of any branch office.

(5) The organizational structure, home health services provided, administrative control and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and shall be readily identifiable. Administrative and supervisory functions shall not be delegated to another agency. All home health services not provided directly by the licensed agency shall be monitored and controlled by that agency.

(6) A governing body (or designated persons so functioning) must: assume full legal authority and responsibility for the management and provision of all home health services; fiscal operations; quality assessment and performance improvement programs. The governing body shall appoint a qualified administrator who is responsible for the day-to-day operation of the organization and is responsible for designating people to carry out these functions.

(7) The administrator shall organize and direct the organization's ongoing functions; the professional personnel and the staff; employ qualified personnel and ensure adequate staff education and evaluation for all personnel involved in direct patient care; ensure the accuracy of public information materials and activities; and implement an effective budgeting and accounting system. A person with sufficient experience and training shall be authorized in writing to assume temporary duty during the administrator's short-term absence.

(8) An agency shall have a duly qualified administrator accessible during normal operating hours. Any change of administrators shall be reported to the Department within fifteen (15) days.

(9) An administrator shall serve no more than one (1) licensed home care organization, which may provide home health, hospice, and/or home medical equipment services.

(10) The agency shall maintain an office with a working telephone and be staffed during normal business hours.

(11) When licensure is applicable for a particular position of employment, a copy of the current license or the number and renewal number of the employee's current license must be maintained in the employee's personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Proof of adequate medical screenings to exclude communicable disease shall be maintained in the file of each employee.

(Rule 1200-8-26-.04, continued)

(12) Personnel practices shall be supported by written personnel policies. Personnel records shall include at a minimum: job descriptions, verification of references and credentials, and performance evaluations. Personnel records must be kept current.

(13) An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the organization's personnel engaged in delivery of home health services. Each employee shall receive appropriate orientation to the organization, its policies, the employee's position, and the employee's duties. Records shall be maintained which indicate the subject of and attendance at such staff development programs.

(14) If personnel, under hourly or per visit contracts, are utilized by the agency, there shall be a written contract between such personnel and the organization clearly designating:

(a) That patients are accepted for care only by the agency;

(b) Which home health services are to be provided;

(c) That it is necessary to conform to all applicable organization policies including personnel qualifications;

(d) The responsibility for participating in developing plans of care;

(e) The manner in which home health services will be controlled, coordinated and evaluated by the agency;

(f) The procedures for submitting clinical and progress notes, scheduling visits and periodic patient evaluations; and

(g) The procedures for determining charges and reimbursement.

(15) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. An agency which violates a required policy also violates the rule establishing the requirement.

(16) Policies and procedures shall be consistent with professionally recognized standards of practice.

(17) All agencies shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(18) Each agency utilizing students shall establish policies and procedures for their supervision.

(19) No agency shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the Board, the Department, the Department of Human Services Adult Protective Services or the Comptroller of the State Treasury. An agency shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation with them or because a person is subpoenaed to testify at a hearing involving one of these authorities.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-222.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed June 18, 2002; effective September 1, 2002.*

1200-8-26-.05 ADMISSIONS, DISCHARGE, AND TRANSFERS.

(1) Patients shall be accepted to receive home health services on the basis of a reasonable expectation that the patient's medical, nursing and psychosocial needs can be met adequately by the organization in the patient's regular or temporary place of residence.

(2) Care shall follow a written plan of care established and reviewed by a physician, and care shall continue under the supervision of a physician.

(3) The agency staff shall determine if the patient's needs can be met by the organization's services and capabilities.

(4) Every person admitted for care or treatment to any agency covered by these rules shall be under the supervision of a physician, as defined in this chapter, who holds a license in good standing. The name of the patient's attending physician shall be recorded in the patient's medical record.

(5) The agency staff shall obtain the patient's written consent for home health services.

(6) The signed consent form shall be included with the patient's individual clinical record.

(7) A diagnosis must be entered in the admission records of the agency for every person admitted for care or treatment.

(8) No medication or treatment shall be provided to any patient of an agency except on the order of a physician or dentist lawfully authorized to give such an order.

(9) A medical record shall be developed and maintained for each patient admitted.

(10) A discharge plan and summary shall be completed on each patient.

(11) The agency must provide an effective discharge planning process that applies to all patients. The agency's discharge planning process, including discharge policies and procedures, must be in writing and must:

(a) Be developed and/or supervised by a registered nurse, social worker or other appropriately qualified personnel;

(b) Begin upon admission of any patient;

(c) Include the likelihood of a patient's capacity for self-care;

(d) Identify the patient's continuing physical, emotional, housekeeping, transportation, social and other needs;

(e) Involve the patient, the patient's family or individual acting on the patient's behalf, the physician, nursing and social work professionals and other appropriate staff, and must be documented in the patient's medical record; and

(f) Be conducted on an ongoing basis throughout the continuum of care. Coordination of services may involve promoting communication to facilitate family support, social work, nursing care, consultation, referral or other follow-up.

(12) The patient and family members or interested persons must be taught and/or counseled to prepare them for post-agency care.

(Rule 1200-8-26-.05, continued)

(13) The agency shall ensure that no person on the grounds of race, color, national origin or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the agency. The agency shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000.*

1200-8-26-.06 BASIC AGENCY FUNCTIONS.

(1) An agency shall provide at least one of the qualifying home health services directly through agency employees, but may arrange with another licensed organization or health care professional to provide any additional home health services. Home health services provided under arrangements with another licensed home care organization or professional organization shall be subject to a written contract conforming with the requirements of this chapter.

(2) All personnel providing home health services shall assure that their efforts effectively complement one another and support the objectives outlined in the plan of care. The medical record or minutes of case conferences shall establish that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report for each patient shall be sent to the attending physician at least every sixty-two (62) days.

(3) Plan of Care.

(a) The written plan of care, developed in consultation with the organization staff, shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of services, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a patient under a plan of care which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for home health therapy services shall include the specific treatment or modalities to be used and their amount, frequency and duration. The therapist and other organization personnel shall participate in developing the plan of care.

(b) The total plan of care shall be reviewed by the attending physician and agency personnel involved in the patient's care as often as the severity of the patient's condition requires, but at least once every sixty-two (62) days. Evidence of review by the physician must include the physician's signature and date of the review on the plan of care. A facsimile of the physician's signature is acceptable. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.

(4) Drugs and treatments shall be administered by appropriately licensed agency personnel, acting within the scope of their licenses. Oral orders for drugs and treatments shall be given to appropriately licensed personnel acting within the scope of their licenses, immediately recorded, signed and dated, and countersigned and dated by the physician.

(5) Skilled Nursing Services.

(a) The agency shall provide skilled nursing services by or under the supervision of a registered nurse who has no current disciplinary action against his/her license, in accordance with the plan of care. This person shall be available at all times during operating hours and participate in all activities relevant to the professional home health services provided, including the development of qualifications and assignment of personnel.

(b) The registered nurse's duties shall include but are not limited to the following: make the initial evaluation visit, except in those circumstances where the physician has ordered therapy services as the only skilled service; regularly evaluate the patient's nursing needs; initiate the plan of care and necessary revisions; provide those services requiring substantial specialized nursing skill; initiate appropriate preventive and rehabilitative nursing procedures; prepare clinical and progress notes; coordinate services; inform the physician and other personnel of changes in the patient's condition and needs; counsel the patient and family in meeting nursing and related needs; participate in in-service programs; supervise and teach other nursing personnel. The registered nurse or appropriate agency staff shall initially and periodically evaluate drug interactions, duplicative drug therapy and non-compliance to drug therapy.

(c) The licensed practical nurse shall provide services in accordance with agency policies, which may include but are not limited to the following: prepare clinical and progress notes; assist the physician and/or registered nurse in performing specialized procedures; prepare equipment and materials for treatments; observe aseptic technique as required; and assist the patient in learning appropriate self-care techniques.

(d) A registered nurse may make the actual determination and pronouncement of death under the following circumstances:

1. The deceased was receiving the services of a licensed home care organization;

2. The death was anticipated, and the attending physician has agreed in writing to sign the death certificate. Such agreement by the attending physician must be present with the deceased at the place of death;

3. The nurse is licensed by the state; and

4. The nurse is employed by the home care organization providing services to the deceased.

(6) Therapy Services.

(a) All therapy services offered by the agency directly or under arrangement shall be planned, delegated, supervised or provided by a qualified therapist in accordance with the plan of care. A qualified therapist assistant may provide therapy services under the supervision of a qualified therapist in accordance with the plan of care. The therapist shall assist the physician in evaluating the level of function, helping develop the plan of care (revising as necessary), preparing clinical and progress notes, advising and consulting with the family and other agency personnel, and participating in in-service programs.

(b) Speech therapy services shall be provided only by or under supervision of a qualified speech language pathologist or audiologist in good standing.

(c) A qualified therapist may make the initial evaluation visit when therapy is the only skilled service ordered.

(7) Home Health Aide Services.

(a) Aides shall be selected on the basis of such factors as: a sympathetic attitude toward the care of the sick; the ability to read, write and carry out directions; and the maturity and ability to deal effectively with the demands of the job. Aides shall be formally and carefully trained in: methods of assisting patients to achieve maximum self-reliance in nutrition and meal preparation; the aging process and emotional problems of illness; procedures for maintaining a

clean, healthy and pleasant environment; changes in a patient's condition that should be reported; work of the agency and the health team; ethics; confidentiality; respect for human dignity and the awareness of individual differences; and record keeping. Any home health aide training programs must comply with the federal home health aide training and competency regulations. Copies of these regulations may be obtained from the department.

(b) The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Duties may include the performance of simple procedures as an extension of therapy services, personal care, ambulation and exercises, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.

(c) The registered nurse, or appropriate professional staff member if other home health services are provided, shall make a supervisory visit to the patient's residence at least monthly, either when the aide is present to observe and assist or when the aide is absent (preferably alternating visits), to assess the aide's competence in providing care and determine whether goals are being met.

(d) There shall be continuing in-service programs on a regularly scheduled basis with on-the-job training during supervisor visits and more often as needed.

(8) Medical Social Services, when provided, shall be given by a certified master social worker, a licensed clinical social worker, or by a social work assistant employed by the agency and under the supervision of a certified master social worker or licensed clinical social worker, and in accordance with the plan of care. The medical social services provider shall assist the physician and other team members in understanding the significant social and emotional factors related to the health problems, participate in the development of the plan of care, prepare clinical and progress notes, work with the family, utilize appropriate community resources, participate in discharge planning and in-service programs, and act as a consultant to other agency personnel.

(9) Performance Improvement.

(a) An agency shall have a committee to review, at least annually, past and present home health services including contract services, in accordance with a written plan, to determine their appropriateness and effectiveness and to ascertain that professional policies are followed in providing these services.

(b) The objectives of the review committee shall be:

1. To assist the agency in using its personnel and facilities to meet individual and community needs;

2. To identify and correct deficiencies which undermine quality of care and lead to waste of agency and personnel resources;

3. To help the agency make critical judgments regarding the quality and quantity of its services through self-examination;

4. To provide opportunities to evaluate the effectiveness of agency policies and when necessary make recommendations to the administration as to controls or changes needed to assure high standards of patient care;

5. To augment in-service staff education;

6. To provide data needed to satisfy state licensure and certification requirements;

7. To establish criteria to measure the effectiveness and efficiency of the home health services provided to patients; and

8. To develop a record review system for the agency to evaluate the necessity or appropriateness of the home health services provided and their effectiveness and efficiency.

(10) Infection Control.

(a) There must be an active performance improvement program for developing guidelines, policies, procedures and techniques for the prevention, control and investigation of infections and communicable diseases.

(b) Formal provisions must be developed to educate and orient all appropriate personnel and/or family members in the practice of aseptic techniques such as handwashing and scrubbing practices, proper hygiene, use of personal protective equipment, dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies.

(c) Continuing education shall be provided for all agency patient care providers on the cause, effect, transmission, prevention and elimination of infections, as evidenced by the ability to verbalize/or demonstrate an understanding of basic techniques.

(d) The agency shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the agency, a student studying at the agency or other health care provider rendering services at the agency is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(e) The agency and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV and communicable diseases.

(f) Precautions shall be taken to prevent the contamination of sterile and clean supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents.

(11) Medical Records.

(a) A medical record containing past and current findings in accordance with accepted professional standards shall be maintained for every patient receiving home health services. In addition to the plan of care, the record shall contain: appropriate identifying information; name of physician; all medications and treatments; signed and dated clinical notes. Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.

(b) All medical records, either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of patients under mental disability or minority, their complete agency records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the patient, whichever is longer. Records destruction shall be accomplished by burning, shredding

or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the agency's policies and procedures, and no record may be destroyed on an individual basis.

(c) Even if the agency discontinues operations, records shall be maintained as mandated by this chapter and the Tennessee Medical Records Act (T.C.A. §§ 68-11-308). If a patient is transferred to another health care facility or agency, a copy of the record or an abstract shall accompany the patient when the agency is directly involved in the transfer.

(d) Medical records information shall be safeguarded against loss or unauthorized use. Written procedures govern use and removal of records and conditions for release of information. The patient's written consent shall be required for release of information when the release is not otherwise authorized by law.

(e) For purposes of this rule, the requirements for signature or countersignature by a physician or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established protocol or rules.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-304.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed September 13, 2002; effective November 27, 2002.*

1200-8-26-.07 RESERVED.

1200-8-26-.08 RESERVED.

1200-8-26-.09 RESERVED.

1200-8-26-.10 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each agency must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous waste. These policies and procedures must comply with the standards of this rule and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste human blood and blood products such as serum, plasma, and other blood components;

(b) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in patient care; and

(c) Other waste determined to be infectious by the agency in its written policy.

(3) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.

(Rule 1200-8-26-.10, continued)

(a) Contaminated sharps must be directly placed in leakproof, rigid and puncture-resistant containers which must then be tightly sealed.

(b) Infectious and hazardous waste must be secured in fastened plastic bags before placement in a garbage can with other household waste.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(4) After packaging, waste must be handled, transported and stored by methods ensuring containment and preserving of the integrity of the packaging, including the use of secondary containment where necessary.

(5) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons. Waste must be stored in a manner and location which affords protection from animals, precipitation, wind and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.

(6) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the agency must ensure that proper actions are immediately taken to:

(a) Isolate the area;

(b) Repackage all spilled waste and contaminated debris in accordance with the requirements of this rule; and,

(c) Sanitize all contaminated equipment and surfaces appropriately.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000.*

1200-8-26-.11 RECORDS AND REPORTS.

(1) A yearly statistical report, the "Joint Annual Report of Home Care Organizations", shall be submitted to the Department. The forms are mailed to each home care organization by the Department each year. The forms must be completed and returned to the Department as requested.

(2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

1. medication errors;

2. aspiration in a non-intubated patient related to conscious/moderate sedation;

(Rule 1200-8-26-.11, continued)

3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;

4. volume overload leading to pulmonary edema;

5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;

6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;

7. burns of a second or third degree;

8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

   (i) procedure related injury requiring repair or removal of an organ;

   (ii) hemorrhage;

   (iii) displacement, migration or breakage of an implant, device, graft or drain;

   (iv) post operative wound infection following clean or clean/contaminated case;

   (v) any unexpected operation or reoperation related to the primary procedure;

   (vi) hysterectomy in a pregnant woman;

   (vii) ruptured uterus;

   (viii) circumcision;

   (ix) incorrect procedure or incorrect treatment that is invasive;

   (x) wrong patient/wrong site surgical procedure;

   (xi) unintentionally retained foreign body;

   (xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;

   (xiii) criminal acts;

   (xiv) suicide or attempted suicide;

   (xv) elopement from the facility;

   (xvi) infant abduction, or infant discharged to the wrong family;

(Rule 1200-8-26-.11, continued)

(xvii) adult abduction;

(xviii) rape;

(xix) patient altercation;

(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

1. strike by the staff at the facility;

2. external disaster impacting the facility;

3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(c) For health services provided in a "home" setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department's approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.

(Rule 1200-8-26-.11, continued)

(f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.

(g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.

(h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.

(j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility.

(k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.

(l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

(3) The agency shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. They shall be maintained in a single file and shall be made available for inspection during normal business hours to any person who requests to view them:

(a) Department licensure and fire safety inspections and surveys;

(b) Federal Health Care Financing Administration surveys and inspections, if any;

(c) Orders of the Commissioner or Board, if any; and

(Rule 1200-8-26-.11, continued)

(d) Comptroller of the Treasury's audit report and finding, if any.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed April 11, 2003; effective June 25, 2003.*

1200-8-26-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;

(b) To have appropriate assessment and management of pain;

(c) To be involved in the decision making of all aspects of their care;

(d) To be free from mental and physical abuse. Should this right be violated, the agency must notify the Department within five (5) business days and the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. §71-6-101 et seq.;

(e) To refuse treatment. The patient must be informed of the consequences of that decision, and the refusal and its reason must be reported to the physician and documented in the medical record;

(f) To refuse experimental treatment and drugs. The patient's written consent for participation in research must be obtained and retained in his or her medical record; and

(g) To have his or her records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient is mentally incompetent, written consent is required from the patient's legal representative. The agency must have policies to govern access and duplication of the patient's record.

(2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed June 18, 2002; effective September 1, 2002.*

1200-8-26-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING FOR INCOMPETENT PATIENTS.

(1) Pursuant to this Rule, each home health agency shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks decision-making capacity, including but not limited to allowing the withholding of CPR measures from individual patients. The policies and procedures for determining when resuscitative services may be withheld must respect the patient's rights of self-determination. The home health agency must inform the patient and/or the patient's health care decision-maker of these policies and procedures upon admission or at such time as may be appropriate.

(2) The home health agency should identify, after consultation with the family or responsible party, the name of the health care decision-maker for a patient who is incompetent or who lacks decision-making capacity, who will be responsible, along with the treating physician, for making health care decisions, including but not limited to deciding on the issuance of a DNR order.

(3) Health care decisions made by a health care decision-maker must be made in accord with the patient's individual health care instructions, if any, and other wishes to the extent known to the health care decision-maker. If the patient's specific wishes are not known, decisions are to be made in accord with the health care decision-maker's determination of the patient's desires or best interests in light of the personal values and beliefs of the patient to the extent they are known.

(4) In the case of a patient who lacks decision-making capacity and who has not appointed an individual to act on his or her behalf pursuant to an advance directive and who does not have a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must identify the patient's surrogate to make health care decisions on the patient's behalf.

(a) The patient's surrogate shall be an adult who:

1. has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available; and

2. consideration shall if possible be given in order of descending preference for service as a surrogate to:

(i) the patient's spouse,

(ii) the patient's adult child,

(iii) the patient's parent,

(iv) the patient's adult sibling,

(v) any other adult relative of the patient, or

(vi) any other adult who satisfies the requirement under part 1 above.

(b) If none of the individuals eligible to act as a surrogate under subparagraph (a), is reasonably available, the patient's treating physician may make health care decisions for the patient after the treating physician either (i) consults with and obtains the recommendations of an institutional ethics committee, or (ii) consults with a second physician who (A) is not directly involved in the patient's health care; (B) either (i) does not serve in a capacity of decision-making or influence or responsibility over the treating physician, or (ii) for whom the treating physician does not exert decision-making, influence or responsibility; and (C) concurs with the treating physician's decision. For the purposes of this rule, "institutional ethics committee" means a committee of a licensed health care institution which renders advice concerning ethical issues involving health care.

(5) All patients shall be presumed as having consented to CPR unless there is documentation in the medical record that the patient has specified that a DNR order be written. DNR orders may be written to exclude any portion of the CPR measures deemed to be unacceptable.

(6) In the case of an incompetent patient who has appointed an attorney in fact to act on his or her behalf pursuant to an advance directive or who has a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must reflect that the attorney in fact, guardian or conservator has specified that a DNR order be written. In the case of a patient who lacks decision-making capacity and who has not appointed an individual to act on his or her behalf pursuant to an advance directive and who does not have a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must identify the patient's

(Rule 1200-8-26-.13, continued)

surrogate to make health care decisions on the patient's behalf, and reflect that the patient's surrogate and the patient's treating physician have mutually specified that a DNR order be written.

(7) CPR may be withheld from the patient if in the judgment of the treating physician an attempt to resuscitate would be medically futile. Withholding and withdrawal of resuscitative services shall be regarded as identical for the purposes of these regulations.

(8) Procedures for periodic review of DNR orders must be established and maintained. The home health agency must have procedures for allowing revocation or amending DNR orders by the patient, the patient's health care decision-maker, or treating physician. Such change shall be documented in the medical record.

(9) Any treating physician who refuses to enter a DNR order in accordance with provisions set forth above, or to comply with a DNR order, shall promptly advise the patient or the patient's health care decision-maker of this decision. The treating physician shall then:

(a) Make a good faith attempt to transfer the patient to another physician who will honor the DNR order; and,

(b) Permit the patient to obtain another physician.

(10) Each home health agency shall establish, and set forth in writing, a mediation process to deal with any dispute regarding health care decisions, including DNR orders, or the determination of the health care decision-maker.

(11) This rule does not alter any requirements imposed by state or federal law, where applicable, including Title 33, the mental health and developmental disabilities law.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-224.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000. Amendment filed April 28, 2003; effective July 12, 2003.*

1200-8-26-.14 DISASTER PREPAREDNESS.

(1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed May 31, 2000; effective August 14, 2000.*